GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

TRANSITION OF MEDICAID MENTAL HEALTH REHABILITATION SERVICES (MHRS) PAYMENTS TO THE MEDICAL ASSISTANCE ADMINISTRATION (MAA)

Please Note

The transition of payments for MHRS Services to the Medical Assistance Administration meetings will be held on the second and fourth Wednesdays through November 30 to discuss transition issues with providers. Meetings will start at 2:00 p.m. and take place in the 4th floor training room, 64 New York Avenue NE.

Frequently Asked Questions (FAQ)

1. **What are the benefits of this payment system?**

   Answer: Some intended benefits of this changeover are as follows:

   a. The MAA and DMH systems will be closely aligned to minimize denials and ensure that claims move through the system cleanly and quickly
   b. Providers will receive detailed remittance advice along with their Medicaid payments
   c. Providers will have access to the ACS help desk for denial or payment inquires
   d. Providers will receive reimbursement via Electronic Funds Transfer (EFT) which will expedite the process
   e. Providers will have only one billing number as the District implements the National Provider Identifier (NPI) which is mandated as a part of HIPAA administrative simplification (for more information, see the CMS website)

2. **When will the transition occur?**

Answer: Currently DMH expects that claims with dates of service after October 1, 2007 will be forwarded to the MAA for payment and not warranted from eCura. This date is subject to change.

3. **Where should providers submit claims after the transition? Where should providers submit reworked claims?**

   Answer: Providers should continue to submit all initial MHRS claims to DMH.

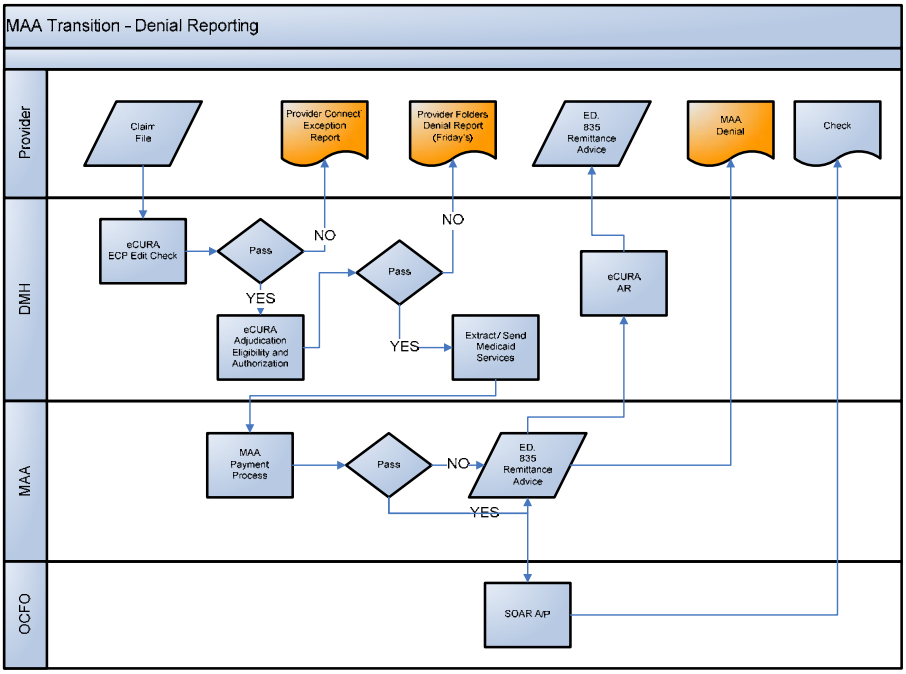
4. **Where should providers submit claims denied by DMH?**

   Answer: Providers should electronically re-submit claims denied by DMH to DMH.

5. **Where should providers submit claims denied by MAA?**

   Answer: In accordance with the MAA Billing Guide, claims denied by MAA should be re-submitted to MAA with a copy of the previously denied claim attached.

Flow Charts for Questions 4 & 5



6. **Will I still need to have an authorization for my claims?**

   Answer: Yes. A DMH authorization is required for all claims in order to be adjudicated.

7. **Will DMH consistently issue reports to providers detailing claims that were forwarded to MAA for adjudication?**

Answer: Yes.

8. **Will providers continue to receive denial reports in a timely manner on claims *that are not sent to MAA* that providers need to re-work? How long will this process take?**

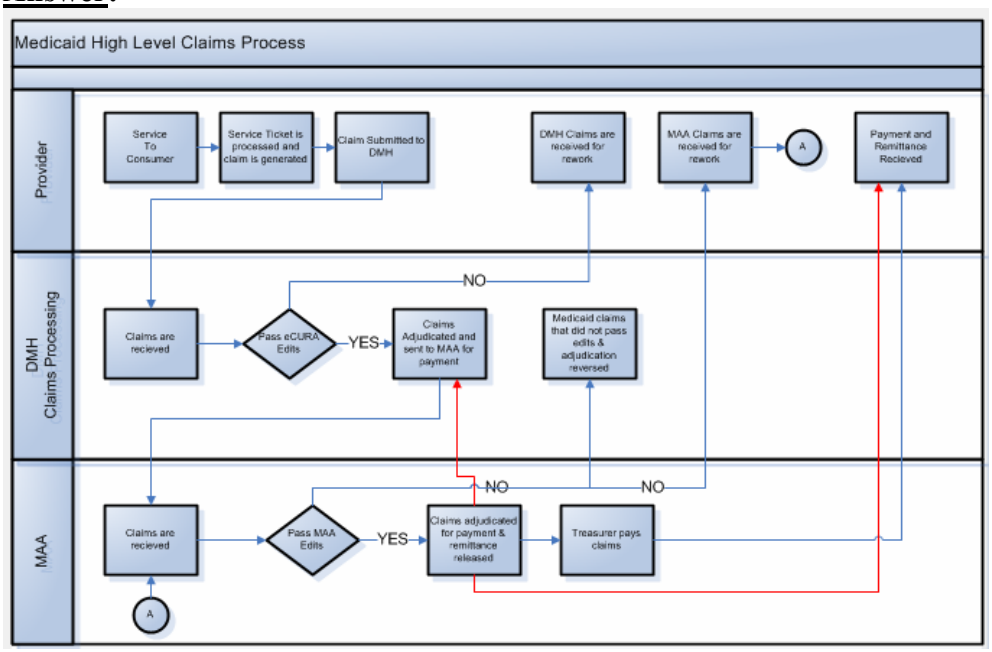
   Answer: Yes. DMH has automated the claims denial reports to be placed in each providers' download folders that are accessed through eCura Provider Connect on a weekly basis. These reports are available on Friday after 12:00 pm.

9. **Will providers receive remittance advice from MAA?**

   Answer: Yes. DMH will place electronic 835s from MAA in the provider's folder. Paper remittances will be mailed with your check from MAA/ACS.

10. **What is the timeline for payment on "clean" claims?**

    Answer:



11. **What will be "timely payments" for both MAA & DMH? Will payments be within 30 days of submission per the DC prompt pay statute?**

    Answer: Payments can be expected to be received within 30 days form the date MAA/ACS receives a clean claim.

12. **Should I submit claims with an NPI number post transition? Who will tell me when to begin using my NPI number?**

Answer: No. Do not submit claims with an NPI number until MAA releases guidance that they are able to accept NPI numbers. DMH will notify providers when this guidance is received.

13. Why is the Department of Mental Health's timely filing requirement important since it is MAA's timely filing that determines payment?

Answer: As required by Title 22, Chapter 34 of the DCMR (MHRS Certification standards), providers have 90 days from the date of service to submit a claim. This allows adequate time for rework of denied claims before they are outside the Medicaid timely filing window (180 days from date of service).

14. How will timely filing be affected when DMH has processing problems which delay processing beyond the timely filing period?

Answer: Providers will have 90 days from date of service to submit all MHRS claims to DMH. All clean claims submitted within the required time frames to DMH will be processed for payment.

15. Must a provider distinguish between local and MAA claims at the point of submission?

Answer: No. However, you will receive payments for Medicaid claims from MAA and local claims from DMH.

16. Is there a new provider number or is the DMH/MHRS number to be used?

Answer: Your current DMH/MHRS provider Medicaid number is to be used.

17. Can one do signature on file with re-submission?

Answer: No. An original signature is required on an paper claim by whomever is authorized to sign claims for your agency. No stamps or copies are allowed.

18. Who is authorized to sign claims forms?

Answer: Whoever the provider designates.

19. **What is the process a provider has to follow to obtain refunds for voided claims?**

Answer: See the ACS pamphlet for instructions.

20. Will the system be tested with a few providers before the go-live date of 10/01/07?

Answer: Yes

21. When will be DMH be enforcing the timelines?

Answer: With dates of services starting 10/01/07.

22. **Where is the field to input the new MAA provider number on the 837 electronic** claim? Will it replace the EIN number?
Answer: The field is MN 109. The new MAA provider number does replace the EIN number.

23. How often will the warrant log be generated?

Answer: Weekly in the provider's download folder.

24. How often will Exception reports be generated?

Answer: Within 24 hours after receipt of a claim.

25. Will all denial codes from DMH and MAA be HIPPA compliant?

Answer: Yes

26. Can ACS provide definitions for "explanation of benefits codes"?

Answer: Providers should contact ACS for clarification of specific codes.

27. Will subproviders be able to request authorizations?

Answer: Sub providers cannot create an auth plan. However, once a plan has been created, the subprovider can edit their services.

28. Is the four (4) units per/day for Medication/Somatic services new?

Answer: No

DMH CONTACT INFORMATION

QUESTION RELATED TO:	CONTACT PERSON	TELEPHONE # EMAIL ADDRESS
Authorizations	Venida Hamilton, Director	202-671-3155

	Provider Relations: Tony Crews, Lead Provider Relations Specialist Joycelyn Alleyne, Provider Relations Specialist	Venida.Hamilton@dc.gov 202-671-2908 Tony.Crews@dc.gov 202-673-7011 Joycelyn.Alleyne@dc.gov
Medicaid Eligibility	Lisa DeLoatch, Medicaid Eligibility Specialist	202-673-3426 Lisa.DeLoatch@dc.gov
Claims Submitted to DMH	Melvin Barry, Claims Supervisor	(202) 671-2987 melvin.barry@dc.gov
DMH Denied Claims	Melvin Barry, Claims Supervisor	(202) 671-2987 melvin.barry@dc.gov
All Other Questions In Writing	Provider Relations	See contact Information Above

MAA/ACS CONTACT INFORMATION

ACS will assist you with your claims questions related to payments or denials.

ACS Provider Inquiry Department

Hours of Operation	Monday-Friday 8 a.m. - 5 p.m.
Phone	202-906-8329 (inside DC Metro area) 866-752-9233 (outside DC Metro area)
Fax	202-9068399
Mailing Address	P.O. Box 34734 Washington, DC 20043-4761

Donna Black, Field Services Representative: 202-906-8335
Derrick Bailey, Provider Relations Manager: 202-905-8332

Frequently Asked Questions
(FAQ- UPDATE)

1. **If paper claims were submitted to MAA, how will DMH know of those claims?**

   Answer: Only denials, adjustments or voids will be re-submitted to MAA as paper claims. DMH will receive an 835 from MAA once MAA processes the paper claim.

2. **Clarification of "Cross Walk" under counseling-no specific code for family therapy.**

   Answer: There is no code for family counseling. This is not a change. There are codes for counseling individual and counseling group. Family/Couple without consumer present should be claimed using H0004 HS or Family/Couple with consumer present should be claimed using H0004 HR.

3. **Will sub-providers be able to request authorizations? Sub-providers/specialty providers are still having issues getting timely authorizations from the CSAs. When is the 30 day rule going to be enforced?**

   Answer: Sub-providers will be able to adjust units once the CSA has put in the authorization for service. Subproviders will be able to add services that they can provide to an authplan where a CSA has already specified them as a rendering provider.
   Enforcement of the 30 day rule will commence for all services rendered as of 10-01-07.

4. **Clarify the difference between the Exception & Denial Report?**

   Answer: An Exception Report indicates claims that do not match information in ecura. Typically it is because diagnosis codes, CPT codes, or Authorization numbers are missing or are incorrect. The Denial report contains those claims that matched data in eCura but are denied during the adjudication process because of insufficient authorized units, exceeding the provider's agreement limit, or dates outside the authorization plan, etc.

5. **Modifier TO (telephone contact)- If this is a payment out of local funds, how will this be tracked/obligated against the agency's Task Order allocation?**

   Answer: Provider will have a PO for local dollars to which all local dollar claims will be posted and tracked.

6. **Is DMH going to expand the authorization system to account for those services that will be local dollars only items, for example, community support & telephone calls?**

   Answer: The system does not need to be expanded. Providers should authorize the service to the correct insurance for situations in which they will be used.

7. **Is there a system for tracking problems with authorizations?**

   Answer: Services that require prior authorization are being tracked.

8. **Where are the codes for TU under community Support, nursing services and is the 4 units per day for medication/somatic new?**

   Answer: The TU codes have never been Medicaid reimbursable, they are local dollar codes. We are continuing to work on resolution regarding billing for nursing medication/somatic services. The maximum of 4 units of medication/somatic per day is not new.

FAQ UPDATE

UPDATE-SEPTEMBER 21, 2007

1. **Why did DMH move the transition date to November 1st instead of October 1st?**

Answer: Through communications from providers and testing with MAA, DMH recognized the misalignment between DMH's and MAA's payment rules for consumers with MCO coverage. This issue was identified in testing with Community Connections (CC) when community support claims were denied for MCO consumers. If we were to leave this unaddressed, it would have created a significant amount of paper rework on the part of MHRS providers.

DMH and MAA jointly agreed to postpone the transition date to November 1, 2007. This extension allows for clarification of the payment policy issue and further testing between DMH and MAA. Consistent with the contingency planning we have put in place, DMH would like to make clear that MHRS providers will continue to submit claims, as they are currently, to DMH. Required task orders for payment continuity to cover this period prior to transition are being put in place.

2. **Why is DMH only testing with Community Connections, and what are the results of that testing?**

Answer: DMH tested the new Authorization functionality with personnel from **Life Stride, Scruples, Careco, and Kidd**. DMH believes these organizations found the software to be a significant improvement over the current authplan operation with the exception of the "not processed error" that was received in the testing. This error has since been corrected in the current version of eCura 4.31 now in production. Following the authorization testing, DMH began testing the electronic 835 with CC, the only provider with a fully operational test copy of their Production database, which was required for testing the end-to-end transition scenario. If any other providers have test systems, and would like to test with DMH, please contact Provider Relations at 202-671-3155.

Please allow DMH to thank CC publicly for all of the time and effort their agency is expending to ensure our processes are working as anticipated. As our only private provider with a separate test platform, their assistance has been vital to demonstrate the potential benefits of the transition.

The results of the 835 testing with CC showed:

- ACS returned a specific 835 for CC
- ACS generated a paper remittance for CC (the only remittance that MAA promised to provide to Mental Health providers after the transition)
- CC was able to import the 835 and generate internal reports from it but was unable to post payments using it because it is addressed to DMH as it should be. This is not a glitch – the 835 is generated by ACS was suppose to be addressed to DMH. During the July 12th meeting, providers were told that MAA would issue paper remittances with the checks. An annotated copy of the paper remittance was also distributed during the July 12th meeting, to assist the providers with interpreting it. If you have questions about the paper remittance, please contact ACS.

3. Are providers required to have a system properly set up to electronically process claims?

Answer: Yes, per DMH certification standards in Chapter 34 of Title 22A of the DCMR:

- 3410.39 Each MHRS provider shall ensure that sufficient resources (e.g. personnel, hardware, software) are available to support the operations of computerized systems for collection, analysis, and reporting of information, along with claims submission.
- 3410.41 Claims for MHRS shall be submitted using the format required by DMH.
- 3411.12 Each CSA shall have the capability to submit timely and accurate claims, encounter data and other submissions as necessary directly to the DMH contract management system.

Per the Human Care Agreement:

- "provider certifies that it has an information management system capable of submitting, documenting and tracking eligibility, service, claims and payment information in accordance with DMH requirements."

We appreciate any assistance providers are offering other providers, however, please refer any providers seeking assistance to DMH Provider Relations at 202-671-3155.

4. Are providers really ready to bill MAA?

Answer: MHRS providers **will not** be billing initial claims to MAA. While DMH does not know individual provider status, we would like to reiterate that all providers will continue to submit claims to DMH with the normal process.

5. Will DMH be able to continue paying claims with dates of service prior to 11/01/2007 while at the same time letting MAA pay claims with dates of service after 11/01/2007?

Answer: DMH is prepared to continue paying FY07 claims while at the same time paying local dollar FY08 claims and send FY08 Medicaid covered claims to MAA's intermediary ACS for payment. DMH will accomplish this by continuing to pay FY07 directly, through March 31, 2008. This is the same process that was used to close out FY 06 claims in FY 07. At the same time, DMH will process and send FY08 Medicaid covered claims to ACS for payment, while paying FY08 local covered claims directly as we do presently.

6. Will DMH continue to be mindful of the eligibility issues and put in place procedures to ensure appropriate eligibility?

Answer: As stated at the July 12th meeting, DMH has hired additional staff and instituted procedures to correct eligibility problems. Specifically, the Access Help Line now checks ACEDS during the enrollment process to determine eligibility at time so as to load the consumer record in eCura with the correct insurance. Two analysts have been hired to assist with eligibility comparisons and realignment following the weekly Medicaid eligibility upload. Lastly, effective June 2007, DMH only loads eligibility data for consumer records with payable program codes. DMH is also working to ensure that acceptable data is submitted to ACS to eliminate unnecessary file rejections for formatting issue that include lack of address data, date sequence, etc. Please keep in mind that accurate determination of eligibility is an ongoing problem that extends beyond DMH.

7. Will the transition cause a whole new flurry of payment problems in the new fiscal year?

Answer: As with any change, unanticipated problems are possible. However, DMH staff is working diligently to make this transition as seamless as possible, and we appreciate our provider's help in this process. If you are aware of any potential issues that are not being addressed, please communicate those concerns to DMH Provider Relations in writing as soon as possible. DMH will be convening a bi-weekly meeting (or call in) to address any concerns that may arise pre and post transition. The first meeting is planned for 9/26/07; please look for a communication from Provider Relations for further information.

8. Are there still authorization issues that the upgrade did not fix?

Answer: Enhancements to the eCura software package currently in production consist of the following additions to the Provider connect module:

Brief Inquiry

- Displays the enrollment date

Authplan View

- Allows providers to fully edit denied authorizations
  - Edit default insurance
  - Edit authplan type
  - Edit provider
  - Edit service line insurance
  - Edit units
  - Edit dates
- Allows providers to partially edit approved authorizations
  - Edit units
  - Edit dates
- Allows Subproviders to add new services when they are authorized to provide at least one service on an Authplan by a CSA
- Allows Subproviders to edit services authorized to them

- Displays Insurance spans
- Processes on Save, no longer requires Authoauth to process service requests
- Implements control of number of days prior days to current for auth Plan Start date
- Allows providers to delete denied service requests from authplans to facilitate plan correction particularly when requests exists that have been denied for overlapping

Messaging

Providers can now send and receive messages to and from one another as well as all other eCura users including Access Helpline, Claims and IT department personnel at the DMH Authority. This module works much like MS Outlook.

Also, future enhancements to the authorization module are planned after the transition. We would also like to note that **these upgrades are <u>not</u> associated with the payments transition**, as all authorizations are and will continue to be made through DMH.

9. Will it be required to know how to set up and use the electronic remittance (835) post transition?

<u>Answer:</u> No, the ability to use the 835 is not a required process. All MHRS providers will receive a paper remittance advice with their checks after MAA adjudication, thereby allowing providers to maintain current reconciliation processes. An example and explanation of this paper remittance was provided at the provider training on July 12th.

However, as a potential productivity improvement, the transition will also allow for automated processing of the 835. We again would like to thank CC for allowing us to test this automated process.

10. Is the 835 file from DMH's eCura complete and able to be automatically read?

<u>Answer:</u> Yes, DMH's 835 was received, imported, and automatically posted without any technical problems by CC. Initially, the file only included payments and not any denials or exceptions. However, as a result of the testing, this issue was identified and addressed. All eCura generated 835s now will include the exceptions and denials.

11. Was the end to end 835 test process with MAA successful?

<u>Answer:</u> Yes, the 835 from MAA is able to be read by DMH. DMH will provide this 835 to each individual provider if requested. DMH would like to note that this file will require some technical reformatting to process automatically.

12. Will the system be ready by October 1, 2007?

<u>Answer:</u> Please refer to Question 1.

13. Does DMH have the ability to turn around the claims received from providers and forwarded to Medicaid?

Answer: Yes. The claims flow was described in detail at the provider training offered on July 12th of this year. Post transition, providers will be issued a report of claims that were sent to Medicaid weekly.

14. Were community support claims for consumers with an MCO or Medicare denied for "other insurance payer as primary" in testing?

Answer: Yes, claims for community support for consumers with MCO coverage were denied by MAA. This issue was identified during testing and is currently under investigation at MAA. Once MAA receives clarification that this service should be paid by Medicaid, MAA will change this payment rule in its system to allow for proper payments.

15. Will medication / somatic services provided by a RN or AP RN for MCO consumers by paid by MAA?

Answer: DMH would like to note that **this issue is not related to the transition**. These claims are currently not being paid because the HCPCS code for nursing services is the same for physicians. The MCOs do not pay for medication / somatic services that are offered by a nurse; however, it is a reimbursable service as per the State Plan. DMH is actively working with MAA to rectify the MMIS system to allow for this specific circumstance, and will inform providers when a solution is agreed upon.

16. Should providers roll-up claims offered in two different locations?

Answer: In order for claims to be paid by MAA, providers must roll-up claims offered at different sites, or the second claim will be denied by MAA as a duplicate. Due to the fact that DMH is required by Dixon to record place of service, post transition, this information will have to be collected through a different means. DMH will be issuing guidance regarding the process required to roll-up claims for payment.

Questions: Contact Provider Relations:

Venida Hamilton	202-671-3155
Joycelyn Alleyne	202-673-7011
Tony Crews	202-671-2908

1. Is it possible to institute a process to have dual-eligible (Medicare/Medicaid) claims for community support paid without any paper rework due to their high volume?

Answer: This issue was addressed with MAA and they stated while technically possible, streamlining of the dual-eligible process would require CMS approval. At this time, Providers must process dual eligible claims as TPL claims in order to remain consistent with CMS's requirements.

Medicare and third party payors represent true third party liability situations in which claims for services to their enrollees would be correctly denied by Medicaid pending demonstration of adjudication of such claims by the third party prior to submission to Medicaid. In those situations where there is Medicare or other third party coverage, claims that have not been submitted to those payor (s) first are correctly denied by Medicaid and must be reworked by the provider consistent with instructions provided by MAA/ACS.

2. Is the 835 sent from MAA to DMH to providers different than an 835 issued directly to a freestanding provider?

Answer: No. ACS provides a HIPAA compliant 835 to DMH which will be made available to providers. If providers cannot edit the header record on the 835, third party translation software is available. Community Connections is investigating the use of such packages.

3. What is the status of outstanding authorization fixes?

Answer: There are no outstanding problems that would preclude providers from correctly entering authorizations. If providers are having specific data problems with authorizations, they should contact an Access HelpLine (AHL) counselors to address specific issues.

4. Does the MAA 835 contain line item control numbers from providers' claims system?

Answer: Yes. Line item control numbers are now correctly carried through the 837 and 835. Final testing with providers to verify this will be done as soon as new test files are provided.

5. How will claims for MCO enrollees for services other than Med/Som, D&A, and counseling be paid? They are currently being denied incorrectly by Medicaid due to MCO enrollment status of the consumer?

Answer: MAA's MMIS contractor can carve-out these specific services that are not reimbursed by MCOs but are part of the MHRS taxonomy, but it will require a systems change. This change must be agreed upon and ordered by the Sr. Deputy Director of

MAA, and has been requested as of October 22, 2007. If a solution is not in place by 11/30/07, DMH will arrange for payment of these claims through eCura, and hold for future reimbursement by MAA when the required system changes have been implemented.

6. Will medication / somatic services provided by a RN or APRN for MCO consumers be paid by MAA?

Answer: According to MAA's Office of Managed Care, medication/somatic services provided by a nurse under the direction of a physician should be paid by the MCOs. Information received by DMH in this regard will be shared with providers.

MAA's MMIS contractor can carve-out these specific services that are not reimbursed by MCOs but are part of the MHRS taxonomy, but it will require a systems change. This change must be agreed upon and ordered by the Sr. Deputy Director of MAA, and has been requested as of October 22, 2007. In addition, DMH and MAA are discussing opportunities for coding changes that could further facilitate claiming for the education component.

7. How will the requirements for MAA's claims submission be reconciled with Dixon data collection requirements?

Answer: In order to facilitate claims being paid, DMH is instructing providers to roll-up same day service claims with different POSs to a place of service of "99- other." The data collection method for the lost POS data will be addressed at a later time once a methodology has been agreed to by relevant stakeholders, including the Court Monitor.

8. Are providers receiving remittances for current claim submissions?

Answer: While providers are being paid for claims submissions, an issue remains with certain remittances that include reverted claims. This reporting issue is still being worked on with the software vendor.

9. Are generic "claim denied" codes present in test files?

Answer: Yes. MAA must send DMH a HIPAA compliant 835, which can only include approved denial codes. These codes are the same codes offered to any standalone MAA provider. Proprietary MMIS denial codes that further delineate specific denial reasons are available on the paper remittance – again, this is consistent with standard MAA processes.

10. Are DC Alliance consumers read as Medicaid in eCura?

Answer: No. As of June 2007, DMH is no longer identifying these claims as Medicaid eligible by filtering of the program codes. DMH is implementing plans to manually re-align the incorrectly listed Medicaid insurance for each consumer to DC Local.

Frequently Asked Questions
(FAQ- UPDATE)-October 31, 2007

1. Why is DMH going ahead with transition without instituting a process to have dual-eligible (Medicare/Medicaid) claims for community support paid without any paper rework due to their high volume?

Answer: We are pleased to announce that MAA will be able to process the dually-eligible Medicare and Medicaid population for community support without the need of a manual crossover process between Medicaid and Medicare. Providers will submit these claims through the normal claims adjudication process. A Medicare denial is not required for reimbursement of this service.

2. Could DMH please provide the ACS billing schedule for FY08?

Answer: (ACS will provide)

3. Confirm that the MAA 835 contains a line item control number from providers' system and document the results through testing.

Answer: The line item control number has been fixed. DMH will continue testing with providers.

4. Confirm and document what services MCOs are required to pay that are rendered by RNs or AP RNs.

Answer: According to MAA's Office of Managed Care, medication/somatic services provided by a nurse under the direction of a physician should be paid by the MCOs. Information received by DMH in this regard will be shared with providers.

5. Who will be paying for MCO consumers' claims for Med/Som, counseling, and D&A rendered outside of the clinic setting?

Answer: MAA's MMIS contractor can carve-out these specific services rendered outside the clinical setting that are not reimbursed by MCOs but are part of the MHRS taxonomy. This process will require a systems change within MAA operations. This change must be agreed upon and ordered by the Sr. Deputy Director of MAA. If a solution is not in place by 11/30/07, DMH will arrange for payment of these claims through eCura, and hold for future reimbursement by MAA when the required system changes have been implemented.

6. Why are denial codes for no prior authorization returned from MAA if DMH already adjudicated the claim for prior authorization?

Answer: This issue was identified in testing and is being corrected through on-going system synchronization between MAA and DMH.

7. How linked is the DMH eligibility process with MAA's daily upload?

Answer: DMH receives weekly downloads from MAA.

8. Washington Hospital Center is receiving a "claim denied" code in test files. What does this code mean?

Answer: The code in question is the A1 "Claim Denied Charges." This is a standard pay and report code from Medicaid and should not be treated as a denial code. If there are additional questions regarding Medicaid denial codes, contact ACS at 202-906-8319.

9. Can all providers submit a test file for DMH to process with MAA to see what edits to expect?

Answer: When originally discussed during our July 12, 2007 training, we learned that many providers were not able to take advantage of this opportunity due to limited testing platforms. We are committed to working closely with providers during the transition to ensure a smooth continuation of our Mental Health Delivery System.

10. Do providers' doctors have to be credentialed with MAA in order to submit claims?

Answer: No, providers are credentialed at the organizational level through the Department of Mental Health. No separate credentialing with MAA is required.

11. How can a provider check the current Medicaid eligibility of a consumer?

Answer: For up to date and real-time information use the standard Electronic Verification System (EVS). 202-610-1847

12. What was the result of the investigation of the translation software?

Answer: Pending results from Community Connections

13. What are the timely filing requirements for DMH? How long do I have to rework a DMH denial? How long do I have to rework a MAA denial?

Answer: Please refer to the July 12, 2007 hand-out.

14. How will DMH deal with timely filing denials related delays in authorizations? 14b. and how will DMH handle blank insurance attempts for authorization?
Answer: Providers are encouraged to begin the authorization process prior to the admission or treatment date. Waiting until 30 days will have a significant impact on your total accounts receivable (AR) management.

14b. If you encounter a blank insurance field, please contact DMH's Eligibility Specialist at 202-673-3426 or email at Lisa.Deloatch@dc.gov

15. Are any authorizations required from MAA for MHRS claims?

Answer: All MHRS services must be authorized by DMH.

16. What is the official roll-up policy after November 1st?

Answer: This will be communicated to providers via and updated roll-up procedure bulletin.

ROLL- UP OF CLAIMS:

The Current Roll-Up Procedure:
If all of the following conditions exist claims are rolled-up:

- Same provider
- Same consumer
- Same date of service
- Same service code
- Same modifier
- Same place of service

Change in Procedure Effective November 1, 2007:
If the place of service is different and all of the other above conditions exist, continue to roll-up the claims; **however for place of service use code 99**.

17. How will DMH be collecting the required Dixon data?

Answer: DMH has identified a number of potential options and is currently working with relevant stakeholders to establish and obtain approval for a data collection process.

18. What is wrong with Provider Connect upload/download processes, and when will they be fixed?

Answer: DMH is scanning its current system utilization patterns for systemic drain anomalies and will correct accordingly.

19. How will claims for consumers be paid if the consumer goes in and out of Medicaid eligibility during a 90 day authorization period? How will providers know when to resubmit a claim that was originally thought to be Medicaid to DMH for local payment, and how will DMH account for this payment?

Answer: Claims will be paid according to the current membership eligibility. If a provider believes a claim was incorrectly denied by either DMH or MAA for eligibility the provider should contact the DMH eligibility Specialist, and will not need to resubmit this claim. DMH will re-adjudicate accordingly.

20. When will the realignment of Alliance consumers' insurance be complete?
Answer: November 1, 2007

Frequently Asked Questions
(FAQ- UPDATE)-November 14, 2007

1. Confirm and document what services MCOs are required to pay that are rendered by RNs or AP RNs.

Answer: According to MAA's Office of Managed Care, medication/somatic services provided by a nurse under the direction of a physician should be paid by the MCOs. Information received by DMH in this regard will be shared with providers.

2. Who will be paying for MCO consumers' claims for Med/Som, counseling, and D&A rendered outside of the clinic setting?

Answer: MAA's MMIS contractor can carve-out these specific services rendered outside the clinical setting that are not reimbursed by MCOs but are part of the MHRS taxonomy. This process will require a systems change within MAA operations. This change must be agreed upon and ordered by the Sr. Deputy Director of MAA. If a solution is not in place by 11/30/07, DMH will arrange for payment of these claims through eCura, and hold for future reimbursement by MAA when the required system changes have been implemented.

3. Why are denial codes for no prior authorization returned from MAA if DMH already adjudicated the claim for prior authorization?
Answer: This issue was identified in testing and is being corrected through on-going system synchronization between MAA and DMH.

4. What was the result of the investigation of the translation software?

Answer: Pending results from Community Connections

5. How will DMH be collecting the required Dixon data?

Answer: DMH has identified a number of potential options and is currently working with relevant stakeholders to establish and obtain approval for a data collection process.

6. What is wrong with Provider Connect upload/download processes, and when will they be fixed?

Answer: DMH is scanning its current system utilization patterns for systemic drain anomalies and will correct accordingly.

7. Some providers have not received a claims remittance file since August, when can we expect to receive an updated?

Answer: Providers with any outstanding claims remittance files should contact Melvin Barry at DMH.

Frequently Asked Questions
(FAQ- UPDATE)-November 28, 2007

1. Which services will the MHRS program pay for MCO enrollees?

Answer: The Senior Deputy Director of MAA approved a MMIS carve-out for community support, community based intervention (CBI), and assertive community treatment (ACT) for MCO consumers on November 1st, 2007. DMH will adjudicate proper claims for these services and send them to MAA for payment through the MMIS carve-out. Claims for other MHR Services must be submitted to the MCOs due to the inclusion of the services in the capitated rates of the MCOs.

2. When will the carve-out be in place in MMIS?

Answer: MAA's MMIS contractor is currently testing the carve-out with an expected implementation in early December. DMH will push forward MCO carve-out claims at that time to eliminate the need for a rework cycle by providers.

3. What should providers do if a denial is received from the MCOs for services also covered by MHRS?

Answer: Providers should appeal the claim according to the appeals policy listed in their MCO contract.

4. Why are denial codes for no prior authorization returned from MAA if DMH already adjudicated the claim for prior authorization?

Answer: This issue was identified in testing and is being corrected through on-going system synchronization between MAA and DMH. MAA is currently working with ACS to resolve this issue and expects a solution to be in place by early December. DMH will push forward claims receiving this denial code upon implementation to eliminate the need for a rework cycle by providers.

5. What was the result of the investigation of the translation software?

Answer: Pending results from Community Connections

Frequently Asked Questions
(FAQ- UPDATE)-December 5, 2007

1. Which services will the MHRS program pay for MCO enrollees?

Answer: The Senior Deputy Director of MAA has approved a MMIS carve-out for community support, community based intervention (CBI), and assertive community treatment (ACT) for MCO consumers. Claims for these services will be paid on a Fee-For-Service (FFS) basis and should be directed to DMH for processing just as any other FFS claim.

Based on the results of a recent meeting regarding reimbursement for medication somatic services, MCOs will provide a set of codes and instructions to be used by providers in properly billing the MCOs for Med/Som services attendant to administering medication. DMH will facilitate the distribution of that information to all providers.

A process for submission of claims for day services and intensive day services for MCO enrollees is still under discussion with MAA.

All MHRS services to MCO enrollees, other than those discussed above, should be billed to the MCOs if you participate in the MCO network. If you do not, please notify the MCO or DMH for referral information for the MCO enrollee.

2. How will DMH deal with timely filing for claims eCura related delays in authorizations? (e.g., blank insurance)

Answer: This was previously addressed in the FAQ #5 as following: Providers are encouraged to begin the authorization process prior to the admission or treatment date. Waiting 30 days will have a significant impact on your total AR management and dollars in AR. If you encounter a blank insurance field, please contact DMH's Eligibility Specialist at 202-673-3426 or email at Lisa.Deloatch@dc.gov

3. Could DMH provide a list of valid provisional diagnosis codes?
Answer: Please see Provider Bulletin #36

4. Are providers receiving remittance advices for claim submissions since August?

Answer: Yes, this process has been corrected and all providers with outstanding remittances will receive them within the next 2 weeks.

5. Are providers receiving denial and exception reports?

Answer: DMH has moved to providing the denial reports weekly instead of monthly. Providers will have access to their denial reports by Tuesday of each week. Exception reports are still provided through the provider connect module.

6. When will DMH load local funding for 2008?
Answer: All 2008 monies have been loaded. Funds are being reviewed by Policy Program Staff and will be finalized this Friday.

7. What are the results testing with Community Connections (CC)?
Answer: CC was able to import and post the ACS 835 against claims submitted to DMH after modification of the 835 header.

Frequently Asked Questions
(FAQ- UPDATE)-December 19, 2007

1. How will DMH deal with timely filing for claims eCura related delays in authorizations? (e.g., blank insurance)
Answer: This was previously addressed in the FAQ #5 as following: Providers are encouraged to begin the authorization process prior to the admission or treatment date. Waiting 30 days will have a significant impact on your total AR management and dollars in AR. If you encounter a blank insurance field, please contact DMH's Eligibility Specialist at 202-673-3426 or email at Lisa.Deloatch@dc.gov
DMH is currently collecting data on the Ms. Deloatch's calls volume and response time.

2. When will DMH load local funding for 2008?
Answer: Adjustments to the 2008 purchase orders for local dollars will be loaded by December 31, 2007.

3. If DMH is not loading the final FY-08 allocations until the end of December, how can providers receive authorizations for services requiring prior approval when the request will be denied for exceeded local dollar funding availability?
Answer: Providers should put the authorization in Provider Connect. Care Coordination will approve the medical necessity if appropriate and deny for lack of available funds:

a. **When the initial adjustments are done for FY-08 local dollars, DMH will run a script that will allow the denied authorizations to process up to the limit of a provider's local dollar funding level.**
b. **Providers will have to continue to monitor their local dollar authorizations allocations and only authorize the clinically appropriate number of units.**

4. Will DMH seek to recover payments to a provider when the consumer is deemed to be Medicaid eligible at the time the service provided and paid out of local dollars?

Answer: **Yes. An overpayment will be created and deducted from the provider's next local payment. At the same time these claims will be sent forward to Medicaid for re-processing.**